DEPARTMENT OF HEALTH AND SOCIAL SECURITY
DEPARTMENT OF HEALTH FOR SCOTLAND

The Responsibilities of the Consultant Grade

Report of the Working Party appointed by the Minister of Health and the Secretary of State for Scotland

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FOREWORD

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The Working Party was appointed in 1968 by the then Minister of Health and the Secretary of State for Scotland. The membership of the Working Party, which was not representative of any organisation but was composed of individual members of the medical profession, is set out on page vi. The Working Party has met for fourteen sessions between 16th September, 1968, and 3rd January, 1969, and has considered written evidence from various sources. It has not invited oral evidence. The Working Party is greatly indebted to the Joint Secretaries for their work in drafting documents and recording discussions. They have also had valuable assistance in research, in preparation of documents and in recording discussions from Miss H. Knight and Dr. J. Kilgour of the Department of Health and Social Security, and Miss J. Ladlay.

The views expressed in this report are those of the Working Party itself, and should not be represented as committing either the Departments or the Professions. The object of the Working Party was to consider the problems of the consultant grade, and our report is presented to Ministers in the hope that it may be used as a working document for discussion.

G. E. GODBER

(*Chairman*)

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I. Preamble

1. The volume of work required for adequate medical care of the population has been greatly enlarged by the increasing sophistication of medicine. Greater precision in diagnosis and treatment is assisted by new technology but requires more medical time. More intensive medical and allied care must accompany the more radical yet safer surgery and the use of more potent and possibly more dangerous drugs. This increase in work has been general but most rapid in new specialties and in diagnostic services such as pathology and radiology. Although automation in pathology and radiology has helped to some extent to meet demands on these specialties, the other specialties cannot be served in this way.

2. The responsibilities and functions of the consultant grade in respect of this volume of work cannot be considered in isolation from those of other grades. The consultant's responsibility to train any junior doctors under him, and his power to delegate work have established a direct relationship between the workload of other hospital grades and that of the consultant.

3. In discussing the consultant grade we have therefore had in mind the need for a coherent relationship between all aspects of general or specialist practice, and for the creation of a career structure that can match the abilities and aspirations of all the young men and women who enter the service.

4. The clinical responsibility of a consultant includes the personal execution or, where possible and appropriate, the delegation and subsequent supervision, of all items of the medical care of patients in his charge. Consultants may share certain aspects of their patients' medical treatment with other consultants or with general practitioners. We have considered in this light the two possible ways in which this medical need can be met:

(i) Routine service work could be delegated to well supervised junior doctors and to a permanent sub-consultant grade. This in our view would cause a great deal of discontent as young men and women rightly expect to apply the full range of skills and judgment which they have acquired.

(ii) Medical work in hospitals could be so arranged that the nature of the service contribution of junior doctors is appropriate to the requirements of their training. Consultants would be supported by an increasing number of general practitioners and others working part-time in hospital, and by juniors but only to the extent dictated primarily by training programmes which would lead these juniors in due course to consultant or general practice. Each individual consultant following an increase in the number of consultants would be enabled to carry out more items of care himself for any individual patient than is at present possible.

5. We think that these two courses are to a large extent mutually exclusive and that no alternative exists. We propose to elaborate on our contention that the second course, which is already accepted in some hospitals, is the one that should be followed for the future.

II. Development of the Present Structure

6. The existing career structure in the hospital service has developed from the

ideas and concepts established by two reports in particular—the Spens Committee's Report 1948 and the Report of the Platt Working Party in 1961.

(i) *The Spens Committee* was faced with a situation where training was haphazard, and the functions of the consultant were undefined. Posts were few, the conditions of practice variable, competition was severe, and the failure rate was high. The Spens Committee therefore recommended that three definite training grades should be established above that of House Officer, and that doctors should attain consultant status when they were approximately 32 years old. The Spens Committee also established equality of status and pay within the consultant grade—recommending as an incentive within the grade the merit awards system which the Royal Commission on Doctors' and Dentists' pay (the Pilkington Report) later endorsed. In subsequent discussions it was found that there were a number of pre-N.H.S. doctors who were unable to assume the full responsibility assigned to the consultant grade in the Spens Committee's report, and a sub-consultant grade of senior hospital medical officer was therefore established.

(ii) *Between the reports of the Spens Committee and Platt Working Party* the concept of the grades between house officer and senior registrar as grades primarily for training was eroded by increasing service demands. The profession also became discontented with the senior hospital medical officer grade many of whose members appeared to be doing work very similar to that of the consultant but without consultant status or pay.

(iii) *The Platt Working Party's Report* attempted to solve the problem caused by the senior hospital medical officer grade by designating the consultant as the only doctor who should be finally responsible for the care of patients in hospital beds other than those assigned to general practitioners, and by suggesting that some routine service work below the grade of consultant could be delegated to a grade which, unlike the senior hospital medical officer, would be clearly distinguishable from the consultant grade in responsibility, status and name—the Medical Assistant Grade.

7. Since the Platt Working Party's report there has been considerable dissatisfaction both with the lack of a planned training programme—causing unnecessary delays before appointment to a consultant vacancy—and with the medical assistant grade. In the past year two reports have been published which attempted to solve these problems:

(*a*) The Final Joint Report on the Negotiations between the Health Departments and the National Health Service Hospital Doctors and Dentists contained the report of a subcommittee, Panel 1, which recommended increasing the number of consultant posts, relating the number of training posts—which should be of limited tenure—to the number of career posts in the National Health Service and elsewhere, and providing expert careers advice. Panel I endorsed the Platt Working Party's concept of the consultant, and retained the medical assistant grade—although with better salary, conditions and prospects.

(*b*) The report of the Royal Commission on Medical Education recommended not only a planned programme of postgraduate training through

two recognised training grades, but also suggested that the medical assistant grade should be replaced by a specialist grade in which doctors would exercise "a substantial degree of independent clinical judgment". This recommendation implied a reappraisal of the Platt Working Party's concept of the role of the consultant.

8. There is a close similarity in the junior staffing structure proposed on the one hand by the Royal Commission on Medical Education and on the other by the Final Joint Report on the Negotiations between the Health Departments and the National Health Service Hospital Doctors and Dentists. From the point of proposed vocational registration onwards, however, the career structure suggested by the Royal Commission differs substantially both from that in the Final Joint Report and from existing practice.

A more detailed historical background to the present situation is provided in Appendix A.

III. The Origins of the Existing Situation

9. The pre-1948 situation worked reasonably well at a time when consultant services were relatively sparse and unevenly distributed, and when specialty divisions were so broad that those who did not succeed in obtaining the position they sought still had acceptable career prospects in other forms of medical practice. It would be untenable now, as would be the situation where eligibility for consultant posts was confined to those able and willing to support themselves from their own resources for several years. Nevertheless, important elements of this concept still persist, particularly the acceptance of a period of apprenticeship of undefined length with a high failure rate at the end of that period; and with succession to a vacancy as the only mark of the successful completion of the course. These features of the past have continued into the present system without the flexibility which existed when medicine was less complex so that outlets to alternative medical work were available at all levels of training.

10. Failure to reach a consultancy has now, as a result of the much higher degree of specialisation involved, much more serious consequences than before. The absence of any appropriate outlet for the skills that have been acquired means frustration for the doctor concerned and wastage for the community. Moreover, general practice now needs planned preparation just as much as the hospital specialties, and the work of any newly-qualified doctor should take account of this.

11. Long apprenticeship and selection involving a high failure rate at an increasing late stage are therefore vestiges of a previous system for which more effective alternatives have to be found.

12. The Platt Working Party accepted that the consultant's position gave him the right and the opportunity to select work of the more difficult kind in his specialty, and to delegate the remainder to someone under his supervision.

IV. The Difficulties in the Existing Situation

13. While at present some consultants assume all or most of the medical work themselves, evidence made available to the Working Party shows that the amount and kind of delegation varies considerably and that the majority of consultants still have junior staff to whom delegation is possible. The range of

work undertaken by the consultant himself varies according to local circumstances, the specialty concerned, and the number of junior staff involved.

14. The substantial increase in the number of consultants which followed the recommendations of the Platt Working Party has been accompanied by a more than commensurate increase in the number of juniors. The table at Appendix B shows the rise in the numbers of senior and junior hospital medical and dental staff in Great Britain 1961–68. The opportunity to delegate work and responsibility is therefore still an important feature of consultant employment in many places, although it is certainly not a universal feature because of the uneven distribution of staff.

15. In recent years a large number of young graduates, who are aspiring to senior registrar posts which many may not achieve, have accumulated in the senior house officer and registrar grades.

16. We have seen the results of studies which show that the period of training from the time of qualification to the time of attaining a consultant appointment is usually 12–14 years. The period of post-graduate training and experience required to achieve an acceptable level of competence in a speciality in Britain is, however, very much less and with proper planning should be of the order of 8 years, as suggested by the Spens Committee and by the Royal Commission on Medical Education, with some variation between specialties. This problem is now engaging the attention of many specialty associations which appear to be confirming the Royal Commission's suggestion.

17. Studies made available to the Working Party show that a consultant appointment at the age of 32 years, recommended as a norm by the Spens Committee, is unusual. Out of the 1,504 paid medical consultants appointed in N.H.S. hospitals in England and Wales, 1st October, 1962–30th September, 1966, only 51 were appointed at an age below 33 years. The mean average ages of first appointment to paid consultant posts in England and Wales in the years ending 30th September, 1963, 1964, 1965, 1966 and 1967 were 39·0 years, 38·8, 38·8, 38·6 and 38·7 years respectively.* The age distribution of the 447 new consultants (other than honorary) appointed in England and Wales between 1.10.66 and 30.9.67 was as follows:

88 (19·7%)	...	30–34 years old
204 (45·6%)	...	35–39 „ „
97 (21·7%)	...	40–44 „ „
40 (8·9%)	...	45–49 „ „
13 (2·9%)	...	50–54 „ „
3 (0·7%)	...	55–59 „ „
2 (0·4%)	...	60–64 „ „

Doctors may spend 2–3 years in senior house officer posts and 3–4 years in registrar posts, and as a result enter the senior registrar grade three or four years late. These doctors and their senior colleagues are placed in an invidious position. If the degree of supervision is exercised which the present staffing structure nominally imposes, efforts are duplicated unnecessarily and the

* The mode ages of first appointment for paid consultants in England and Wales during these years were 38 years, 37 years, 38 years, 36 years and 37 years, and the median ages were 38 years, 38 years, 38 years, 37 years and 38 years respectively.

younger doctors' proper development is hampered: if the supervision is less close, the younger men are left to carry a service burden which may be so much heavier than their grade warrants that there may be at least the appearance of exploitation. Inequalities of geographical distribution complicate this situation still further. In some hospitals consultants and intermediate staff are employed on work appropriate to their experience: in others, consultants may be called on to provide an equally complete service with little or no supporting staff at all; and there are areas of the country where junior doctors spend a considerable part of their time unsupervised. A problem of this sort cannot easily be assessed but sufficient examples have been brought to our notice to show that the situation has changed very little since the Platt Working Party reported adversely upon it. The diagram at Appendix C illustrates the unequal geographical distribution of junior and senior hospital medical staff.

18. In our view it is not in the interests of the service, the profession or the community that this situation should continue. It is wasteful of trained men whose skills cannot be used by the service to the full without the possibility of exploitation; it is conducive to frustration and disillusionment in the profession; and it is an important factor in the migration of skilled doctors because those unable to attain full responsibility in this country will seek it elsewhere.

V. The Level of Competence Required to Exercise Consultant Responsibility

19. The only indication at present that postgraduate training has been satisfactorily completed is the attainment of an appointment, by competitive selection, in the consultant grade. The consultant grade has already expanded and, with continuing pressure both from the public and from the profession for the expansion of specialist services, it could be that expansion in the less popular specialties might be achieved at the expense of quality. It is important that some objective criterion, independent of success in competition for any particular post, should be established to demonstrate the standard of competence necessary for the exercise of independent clinical responsibility.

20. A standard of this sort, determined by levels of education and experience, and independent of appointment to a particular post, is desirable also as an immediate objective of post-graduate training and as public evidence of competence. The introduction of vocational registration as recommended by the Royal Commission seems to be the logical and correct development in the circumstances. The report has therefore assumed the acceptance of vocational registration and has based all further argument upon this assumption.

VI. Principles for the Future

21. Following the reasoning above we conclude that the essential changes required should be based on the following considerations:

A. The Introduction of Vocational Registration

A system of vocational or specialist registration, as recommended in paragraphs 19 and 20 above, is essential not only in the interests of the profession but also to assure the public that a doctor is capable of exercising independent clinical responsibility in his specialty. Vocational registration should be preceded by a designated training programme ordinarily lasting for approxi-

mately 8 years. The patterns of education and training appropriate to particular specialties should be devised by specialist associations nationally recognised as representing the specialty. Training arrangements should be flexible enough to allow for differing aptitudes, for the participation of doctors able to attend only on a part-time basis, and for the return into training of any suitable candidates who have earlier discontinued it. The method of assessment for vocational registration is not for us to determine but we assume that it will indicate that a doctor is competent to exercise independent judgment and to assume full responsibility for the care of individual patients.

Immediately after a doctor has attained vocational registration he should be given the opportunity of actually assuming responsibility in that specialty —either in the uncompleted portion of his existing appointment or in some other post. If the responsible professional body, presumably the General Medical Council in consultation with the colleges, decides that vocational registration should only be awarded after a specified length of time in training, however, doctors would only be eligible for registration at the end of their training appointments, and any opportunity of assuming responsibility in their specialty would therefore have to be by appointment to some other post. Until statutory registration is possible interim arrangements may be required.

B. The Responsibility of the Consultant Grade

For a doctor who has completed his hospital specialty training there should be one permanent career grade, that of consultant. He may be defined in the following terms:

"A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after completing training in a specialty and, in future, being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post."

C. Equilibrium between Staff in Training and Staff in Career Posts

There must be equilibrium between numbers of staff in specialty training and staff in career posts, bearing in mind that there will be in addition a large proportion of staff who will be training for work outside the hospital service. Training posts should therefore exist only in such numbers as are required to give appropriate post-graduate experience before the assumption of full responsibility (whether in hospital or outside), and to allow for the re-entry into training envisaged in paragraph (A) above. The problem of overseas graduates is discussed in paragraph 26 below.

D. The General Practitioner in Hospital

General practitioners will play an increasingly important part in hospital work, and permanent part-time posts for them and for other doctors only able to work part-time should be provided at a level appropriate to their professional experience and registration. It should be open to doctors in this grade to apply for part-time training posts directed to vocational registration in a hospital specialty.

VII. Implications

22. If the principles outlined above are accepted and are to be implemented the existing hospital staffing structure will need adaptation. It will follow that if the number of training posts is brought more definitely into line with the number of expected vacancies in the consultant grade, in general practice, and in other fields, many consultants may have less juniors who will remain a shorter time in post, and there will be fewer experienced registrars. It must therefore be necessary for hospital boards to plan a progressive increase in the consultant establishment—particularly for those hospitals where a large proportion of the specialist work has in the past been delegated to junior staff. Without control of the growth of the staffing structure, it can only become less satisfactory even than it is now. Integration in the hospital service such as a divisional system would help to ensure an even distribution of work at different levels of responsibility and also the provision of special arrangements for emergencies. It would also help to provide the necessary atmosphere of co-operation between senior and junior staff.

23. It seems likely that vocational registration will partly depend on the completion of a finite period of time in a training programme. Thus the date of attainment of vocational registration will be foreseeable some months in advance and, therefore, we suggest that, wherever possible, doctors should be appointed proleptically to consultant posts during the last year of their training period—on the understanding that they could only take up the post upon their achieving vocational registration. We see this as a means of ensuring progression to a permanent appointment immediately after vocational registration. Doctors who have not obtained a proleptic appointment should be offered bridging appointments, such as locum consultants, while they are seeking a permanent appointment. The precise nature of these appointments would be a matter for negotiation with the profession. The N.H.S. should accept the responsibility to regulate the numbers in consultant and hospital specialty training grades so that trainees can be sure that posts commensurate with their knowledge and experience would normally be available at the end of their training. The actual appointment to a permanent consultant post would however remain a matter of selection by open competition. There should be no difficulty in ensuring that sufficient general or specialist practice posts exist if the needs of the service continue as at present.

24. If doctors are appointed to posts of consultant responsibility after approximately eight years of postgraduate training, their period of independent practice and consultant responsibility will occupy a higher proportion of their professional life-time than at present. Much of the development of individual interests and special skills which now begins in the later years of senior registrarship will in future take place in a permanent career post of full responsibility. It would be logical therefore for those in the early years of their first consultant post to look for realistic prospects of adjusting their work at some later date so that its emphasis was in keeping with any particular aptitudes that they might have developed. The Royal Commission on Medical Education recommended that there should be two fully responsible grades of "specialist" and "consultant" and we can see justification on educational grounds for such an arrangement; but in clinical practice, however, the disadvantages are too

great for such a course to be acceptable. It is not in the interests of either patient or doctor to try to distinguish between two differing kinds of "full" responsibility; the differentiation by grade of two kinds of consultant must carry with it the risk of clinical direction and create difficulties in the development of divisional or other group systems of clinical organisation. We conclude therefore that the need is for a single consultant grade.

25. There remains the problem of providing prospects of development and advancement within this single grade. We have to recognise that there is immobility within the consultant grade at present, the acceptance of the first consultant post often being regarded as a commitment for the remainder of the professional life-time. This arises understandably from the present difficulty of attaining consultant status, from the age at which this point is reached, and from other factors; but it results in an undesirable tendency to accumulate experience in senior registrar posts and to wait for even remote possibilities of appointments in major centres. A substantial lowering of the age of entry into fully responsible practice and the introduction of a better balance between the numbers of training and permanent posts will offset this tendency to some extent, but cannot of themselves be expected to ensure a more even distribution of consultant skills nor to create the mobility which we believe to be necessary. We see the need therefore for Regional Boards and Boards of Governors to be prepared to advertise certain vacancies as being suitable for applicants who already have experience in the consultant grade, and to ensure that no financial disadvantage is incurred in moving to them. This arrangement would be particularly appropriate for posts with a major teaching element or requiring some special experience. Ideally, a proportion of the consultant posts in teaching hospitals should regularly be filled by those who are already experienced consultants. If this solution can be agreed by the profession, we hope that the Health Departments will take steps with Regional Hospital Boards and Boards of Governors to secure it, and that young doctors might then be encouraged to seek preliminary experience in centres other than those in which they were trained.

26. Our report has been mainly concerned with the requirements of graduates from our own medical schools. We understand, however, that out of 14,822 doctors in the hospital training grades (pre-registration House Officer to Senior Registrar) in Great Britain at 30th September, 1968, 6,626 were born outside the United Kingdom and the Irish Republic although some of these will be British citizens. Some of these doctors would be accommodated in the training arrangements proposed. A further influx of large numbers of overseas doctors could however distort the staffing structure and impede the training arrangements made. The Royal Commission on Medical Education drew attention to the haphazard nature of much of the training received by many young doctors from overseas. We recommend that this country should continue to encourage those doctors who are accredited by their Universities or other appropriate bodies to come here for further training. There would however be less opportunity for large numbers of other overseas doctors in the hospital service. Overseas doctors who are accepted for further training in this country should be carefully selected to ensure that they will benefit from the training received, and they should be encouraged to return to their own countries on the com-

pletion of training. In making this recommendation we have had in mind the shortage of doctors in countries overseas to which the Royal Commission on Medical Education drew attention.

27. Provision should be made in the consultant and the hospital specialty training grades for those doctors who for various reasons can only do part time work—for example married women—but who have attained vocational registration in a specialty or who wish to take part in a suitably adapted training programme leading to vocational registration.

28. General Practitioners and other doctors such as married women who are not vocationally registered in a hospital specialty and wish to work part-time only in the hospital service should be able to assume the level of responsibility suitable to their qualifications within their own hospital grade with its own career structure and salary scale.

29. Arrangements will be necessary for those few doctors who after training have been unable to obtain vocational registration and yet who are suitable and personally apply to remain in a whole-time hospital post with limited responsibility. This is not however a grade for which there should be an establishment, and each appointment should be specifically authorised for each individual at his request.

30. The method of assimilating existing long service senior registrars and registrars, and doctors in permanent career grades into the proposed new career structure would be a matter for negotiation with the profession.

31. We would emphasise that the number of doctors engaged in hospital work can only increase at a modest rate allowing also for the needs of general practice. As far as immediate changes in the hospital staffing structure are concerned any expansion will mainly involve accelerated movement of suitably qualified other staff into permanent career posts. Any expansion of the consultant grade cannot be allowed to cause even a temporary lowering of standards. We are confident that standards will continue to rise progressively and that the introduction of vocational registration and controlled training will contribute substantially to this end.

APPENDIX A

Summary of past practice and reports which are concerned with the derivation and distribution of clinical responsibility

Situation before 1948

Before 1948, the doctor seeking a consultant post sought for resident and then senior training posts, usually in the teaching hospitals. While holding the former, he studied for his higher degrees. Although these training posts were poorly remunerated, competition for them was intense and became more so with increasing seniority. Many doctors could not proceed to consultant posts but were readily able to enter general practice often with a hospital attachment.

The Report on the Remuneration of Consultants and Specialists (Spens Report, 1948)

Among the major recommendations of the Spens Committee's Report, the following are relevant.

It was recommended that there should be equality of status between consultants in different branches of specialist practice and between different hospitals (paragraphs 7–8).

It was recommended (paragraph 9) that above house officer level there should be three grades, known as junior registrar, registrar and senior registrar, held respectively for 1, 2 and 3 years, and leading to a consultant appointment normally about the age of 32 (paragraph 11).

The Report recognised that some specialties demanded very lengthy periods of training, and stressed the difficulty of safeguarding the position of a fully trained doctor awaiting a consultant appointment while at the same time limiting the tenure of training posts.

The Spens Committee further recognised that a consultant undertook sole responsibility for patients under his charge. Referring to differentiation of status among consultants and to the merit award system, they stated "Whilst age or length of service should not, at any time during his tenure of a staff appointment, be the sole factor determining remuneration, there should be during the earlier years, in addition to some means of recognising and rewarding exceptional individual merit, a uniform scale of annual increases in remuneration applicable to all specialists alike" (paragraph 13).

Following the discussions on the Spens Committee's Report, a new grade, that of Senior Hospital Medical Officer, was added to the staffing structure in order to provide a career for doctors transferred to the hospital service who were not trainees but who had not the training and standard necessary to justify grading them as consultants. It was also thought necessary to meet the need for doctors below consultant level to perform work of limited scope, of lower responsibility and requiring less skill than that of consultants, in appointments which should not be of limited tenure. The use of this grade was restricted in agreement with the profession to certain defined fields of work, save for those who remained in it because they were not personally consultant calibre. The number of such doctors was substantial and their contribution to total senior staff even as late as 1955 was roughly one quarter of the total: they were especially numerous in chest diseases and psychiatry.

The Report of the Royal Commission on Doctors and Dentists Remuneration (Pilkington Report) 1960

The Pilkington Commission pointed out (paragraph 179) that the range of work and responsibility undertaken within the same grade could vary considerably. They also emphasised (paragraph 180) that there was a lack of clear definition of the responsibilities of different grades.

In view of suggestions that instead of giving awards to individuals, differentiation in incomes could be obtained by giving higher remuneration to posts with special responsibility, consideration was given to the possibility of a hierarchy of consultant appointments. The Pilkington Commission recommended however the continuance of the awards system as a "practical and imaginative way of securing a reasonable differentiation of income and providing relatively high earnings" for a "significant minority" of consultants. It was thought that the establishment of a hierarchy of consultants presented too many difficulties.

Their terms of reference did not cover specific alterations in the basis of employment in the various grades. This problem was one which came before the next reporting body.

The Report on the Medical Staffing Structure in the Hospital Service (Platt Report) 1961

This report contains a number of important statements and recommendations.

1. The consultant was defined as a person who has been appointed by a statutory hospital authority by reason of his ability, qualifications, training and experience to undertake full personal responsibility for the investigation and/or treatment of patients in one or more hospitals without supervision in professional matters by any other person (paragraph 40).

2. The Platt Working Party was particularly concerned with provision of intermediate staff (between consultant and houseman) to maintain service needs. They appreciated the unsatisfactory nature of the senior hospital medical officer grade and proposed as one solution to the staffing problem that there should be a new grade of unlimited tenure, clearly distinguishable from the consultant grade in responsibility, status and name, which was to be known as the medical assistant grade (paragraphs 121–127).

They accepted, by implication, that the grades between house officer and senior registrar should not necessarily be regarded primarily as training grades for consultant rank.

They recommended, as an additional contribution towards the problem of staffing the intermediate levels, that junior doctors, even those not proposing to make a permanent career in the hospital service, should be persuaded to stay longer in hospital after registration.

The Final Joint Report on the Negotiations between the Health Departments and the National Health Service Hospital Doctors and Dentists

This report was a response to a Memorandum by the profession in which it was maintained that there were too few consultant posts, that training requirements of junior staff were often subordinated to service needs, that there was a lack of integrated training schemes and that the registrar grade had been allowed to grow in an uncontrolled way. We are particularly concerned with the report of a sub-group of the main Working Party, Panel 1.

The main recommendations of Panel 1 were as follows:

(1) The Platt Working Party's concept of the role of the consultant should be retained.

(2) Consultant numbers should be increased and there should be new methods of manpower control.

(3) Measures should be taken to ensure the right number of training posts below consultant, with strictly limited periods of tenure, for those wishing to make a career in the hospital service, together with arrangements for doctors wishing

to pursue a career outside the hospital service and designed to avoid premature commitment to one career.

(4) Expert careers advice should be available.

(5) The assistant grade should be retained though with a more attractive salary and conditions.

The Royal Commission on Medical Education (Todd Report) 1968

The Royal Commission's Report does not in fact attempt to define a consultant and the only reference to this is that consultant status would depend on appointment to a consultant post.

The Royal Commission recommended that fresh consideration should be given to the role of the consultant and proposed that there should be a new grade to be known as hospital specialist, in which doctors would take cases in their own right for the whole period of investigation and treatment.

The distinction between consultants and specialists is not entirely clear but appears to have two bases. The first is clinical and it is suggested that the consultant might hold the leadership of a specialist team and that the specialist might turn to the consultant for advice in particularly difficult cases. The second is administrative with the implication that heads of departments or divisions, but not only they, would be consultants.

It also appears that recruitment to consultant rank would be through the specialist grade and this might be rapid in some instances.

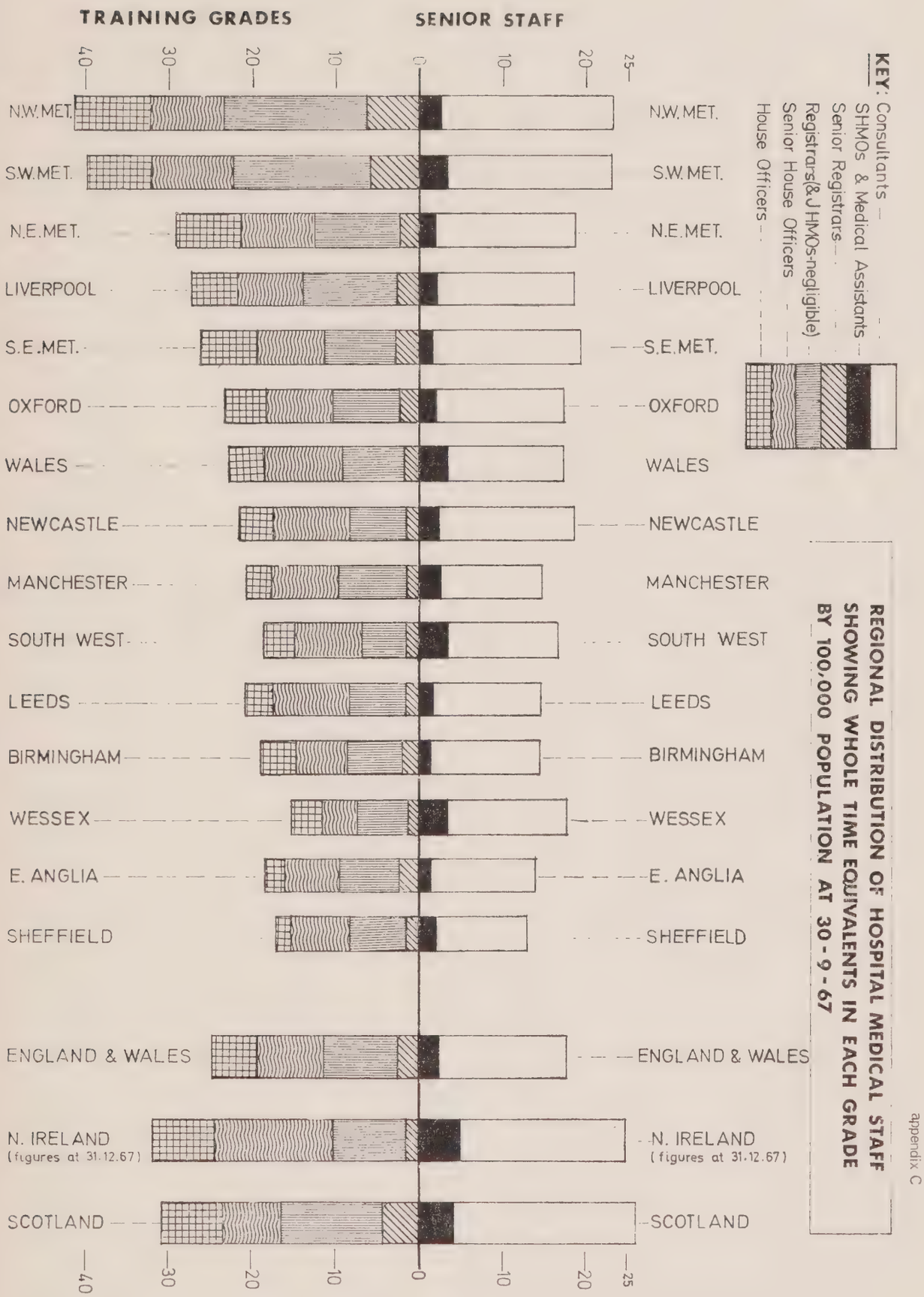
The Commission recommended that the grade of medical assistant should be abolished. There would be one grade of registrar into which doctors would move after their intern year and in which they would spend three years in general professional training. After this they would be eligible for a certificate stating that this period had been completed satisfactorily and would proceed to a period of two or more years of further professional training in the specialty in which they intended to practise. During this time they would be known as junior specialists and towards the end of it would be eligible to be placed on a specialist register. Doctors on the register would be in a position to apply for specialist posts and those of particular merit could subsequently obtain consultant posts by competition.

Numbers of Senior and Junior Hospital Medical and Dental Staff in Great Britain 1961-1968

(*excluding locum staff*)

Grade	1961	1962	1963	1964	1965	1966	1967	1968 (provisional)
Consultants	8,463	8,673	8,930	9,233	10,110	10,433	10,767	11,031
S.H.M.O.s								
Medical Assistants	2,518	2,418	2,280	2,078	1,409	1,599	1,715	1,669
Total Senior Staff	10,981	11,091	11,210	11,311	11,519	12,032	12,482	12,700
Total Junior Staff:								
.....Senior Registrar								
.....Registrar, S.H.O.								
.....J.H.M.O.	12,050	12,576	13,084	13,404	13,946	14,176	14,824	15,489
.....H.O.—post-registration								
.....and pre-registration								
.....Others								
Total Staff	23,031	23,667	24,294	24,715	25,465	26,208	27,306	28,189

APPENDIX C



REGIONAL DISTRIBUTION OF HOSPITAL MEDICAL STAFF SHOWING WHOLE TIME EQUIVALENTS IN EACH GRADE BY 100,000 POPULATION AT 30-9-67

appendix C

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